**UNM Medical Plan Summary Administered by UNM Health**
*July 1, 2016 to June 30, 2017*

**UNM Medical Plan**
- Pre-existing condition exclusions: NONE
- Lifetime Maximum: NONE
- Note: Services outside LoboCare Network require prior authorization

Please refer to your Participant Benefit Booklet for detailed information about UNM Medical Plan coverage including limitations, exclusions, and benefit certification requirements.

<table>
<thead>
<tr>
<th></th>
<th>LoboCare Network</th>
<th>Extended Tier 2 Network (Prior Authorization Required)</th>
<th>Out-of-Network****</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$600 Per Person ($1,200 Family)</td>
<td>$1,800 Per Person ($3,600 Family)</td>
<td></td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximums</strong></td>
<td>$3,000 Per Person ($6,000 Family)**</td>
<td>$7,500 Per Person ($15,000 Family) (Deductible not included)</td>
<td></td>
</tr>
</tbody>
</table>

**Inpatient Hospitalization**
- 10%
- 30%
- 40%***

**Outpatient Procedures**
- 10%
- 30%
- 40%***

**Physician Services:**
- Primary Care (PC) Office Visits
  - 10%
  - 30%
  - 40%***
- Specialist Office Visits
  - 10%
  - 30%
  - 40%***
- Preventive Exams/Services
  - 10%
  - 30%
  - 40%***
- Outpatient Diagnostic Tests/lab/X-Ray (not including CT/PET Scans, MRI, or Nuclear Medicine)
  - 10%
  - 30%
  - 40%***

**CT/PET scans, MRI, Nuclear Medicine**
- 10%
- 30%
- 40%***

**Durable Medical Equipment**
- (Includes prosthetics; orthotics not covered)
  - 10%
  - 30%
  - 40%***

**Mental Health/Substance Addiction**
- Inpatient
  - $35 Copay*
  - $45 Copay*
  - 40%***
- Outpatient
  - $35 Copay*
  - $45 Copay*
  - 40%***

**Home Health Care**
- (100 Visits Per Plan Year)
  - 10%
  - 30%
  - 40%***

**Skilled Nursing Care**
- (60 days/plan year)
  - 10%
  - 30%
  - 40%***

**Speech / Physical / Occupational Therapy**
- (30 visits Physical/20 visits Speech and Occupational Therapy each per plan year)
  - $35 Copay*
  - $45 Copay*
  - 40%***

**Hospice**
- 10%
- 30%
- 40%***

**Ambulance**
- Applies to In-Network Benefit**
- 30%
- Applies to In-Network Benefit**

**World-Wide Emergency Services**
- $150 Copay*
- $150 Copay*
- $150 Copay*

**Urgent Care**
- $75 Copay*
- $75 Copay*
- $75 Copay*
- 40%***

**Chiropractic**
- (20 visits each per plan year)
  - $35 Copay*
  - $45 Copay*
  - 40%***

**Acupuncture**
- (20 visits each per plan year)
  - $35 Copay*
  - $45 Copay*
  - 40%***

**Prescription Drugs**

<table>
<thead>
<tr>
<th>Administered by Express Scripts, Inc.</th>
<th>Pharmacy/30 Day Supply**</th>
<th>Mail Order/Pharmacy 90 Day Supply**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong>*</td>
<td>$10 Copay</td>
<td>$20 Copay</td>
</tr>
<tr>
<td><strong>Formulary Brand</strong>*</td>
<td>25% coinsurance (Min $35 – Max $70)</td>
<td>25% coinsurance (Min $87.50–Max $175)</td>
</tr>
<tr>
<td><strong>Non-Formulary</strong>*</td>
<td>25% coinsurance (Min $55 – Max $110)</td>
<td>25% coinsurance (Min $137.50–Max $275.00)</td>
</tr>
<tr>
<td><strong>Specialty</strong>*</td>
<td>20% to maximum $250/prescription; after reaching $1,250 out of pocket within plan year, then $55 Co-Pay</td>
<td>Not Available</td>
</tr>
</tbody>
</table>

*Not Subject to Deductible

**Combined LoboCare and In-Network Out-of-Pocket Maximums include deductibles, flat dollar copays, and coinsurance paid

***Applies to Out-of-Network Deductible and Out-of-Pocket Maximum

****Amounts above Reasonable and Customary are not covered